Operational Policy Letter #11

Department Of Health & Human Services

Health Care Financing Administration

Medicare Managed Care

April 11, 1995

ADMINISTRATIVE REVIEW RIGHTS FOR HCPP ENROLLEES

ISSUE:

The Office of Manged Care has developed a program memorandum explaining the final rule entitled "Appeal Rights and Procedures for Beneficiaries Enrolled in Prepaid Health Care Plans." The program memorandum, which includes questions and answers concerning the rule, is attached to this Operational Policy letter.

Contact:

HCFA Regional Office Managed Care Staff

PROGRAM INFORMATION MEMORANDUM

Notice to: Health Care Prepayment Plans

Subject: Providing Administrative Review Rights to HCPP Members

A final rule entitled "Appeal Rights and Procedures for Beneficiaries Enrolled in Prepaid Health Care Plans," was published in the Federal Register (Vol. 59, No. 223, pp. 59933-43) on November 21, 1994. One provision of this rule gives Medicare enrollees of Health Care Prepayment Plans (HCPPs) the right to request administrative review of their health plans' decisions to deny medical services or claims. The purpose of this notice is to provide guidance to you on implementing this procedure which is mandated by the new regulations at 42 CFR 417.801 and 417.830 through 417.840.

Starting May 22, 1995, each HCPP must issue a written notice of appeal rights with each organization determination that is partially or fully adverse to the enrollee. This requirement applies only to services that are provided by the health plan under the HCPP agreement with the Health Care Financing Administration (HCFA).

Notification of Medicare Enrollees

You must inform all of your Medicare enrollees of this new appeal right. A notice sent to each beneficiary that explains this new right is an acceptable way to communicate this information. Until you reprint your Evidence of Coverage (EOC), you should include an appeals information addendum sheet with the EOC.

Establishing Administrative Review Procedures

The new regulations require that a Medicare HCPP enrollee shall have a full range of appeal rights if the organization refuses to provide, arrange, or reimburse (if obtained outside of the HCPP) for covered services that the enrollee believes (s)he is entitled to.

The enrollee is first entitled to a reconsideration of the HCPP's determination. If the health plan partly or completely upholds its denial, the case must be sent to HCFA's contractor, Network Design Group (NDG), to complete the reconsideration process. Administrative Law Judge hearings, Appeals Council review, and judicial review may be available if the beneficiary wishes to continue to appeal adverse decisions and the amount in controversy meets established thresholds. Further, determinations may be reopened under some circumstances.

HCPPs must carry out the various steps in the appeals process in accordance with the regulations at 417.608 to 417.638, as amended November 21, 1994. (copy attached) To assist you in implementing your new obligation, we are attaching: "Questions and Answers" about the appeals process that includes a sample adverse organization determination letter; instructions for filing cases with NDG; and a newsletter from NDG.

Regional Office Approval

Please submit the following documents to your Regional Office coordinator so they can be reviewed in time for your preparation of your mailing to beneficiaries:

1. Copies of the notice explaining the new administrative review right for distribution to your current and future enrollees and Evidence of Coverage addendum sheet.

1. A description of your Medicare reconsideration procedures, including an explanation of what types of disagreements will qualify for these procedures instead of the member grievance procedure.

- Draft notice to beneficiaries of the HCPP's adverse organization determination, which specifies appeal rights.

If you have any questions, you may contact your Regional Office coordinator.

Rodney C. Armstead, M.D.

Director

HMO/CMP/HCPP APPEALS PROCESS QUESTIONS AND ANSWERS

1. What is the HMO/CMP/HCPP enrollee appeal process?

The HMO/CMP/HCPP appeals process is a series of procedures incorporated in the Federal Regulations that address disputes about payment for or receipt of services involving Medicare enrollees of an HMO/CMP/HCPP. The procedures apply to HMOs/CMPs that have Medicare contracts and demonstrations with the Health Care Financing Administration (HCFA) as well as HCPPs that have agreements with HCFA. The regulations governing the appeals process are set forth at 42 CFR 417.600-417.638 for HMOs and CMPs, and 42 CFR 417.830-417.840 for HCPPs. Also see the Medicare Health Maintenance Organization/ Competitive Medical Plan Manual, Transmittal No. 6, March 1991, Part 2, Chapter 5, Beneficiary Appeals and Grievances.

2. How does the HMO/CMP/HCPP internal grievance process differ from the appeals process?

The HMO/CMP/HCPP internal grievance procedure applies only when the Medicare appeals procedure does not apply. The HMO/CMP/HCPP appeals process for its Medicare enrollees must be used to resolve disputes over denial of payment for Medicare services, the provision of Medicare services, and/or services covered under the Medicare contract or HCPP agreement. For HCPPs, the appeals procedure applies only to services that are covered by the health plan under the HCPP agreement with the HCFA. These include:

a. reimbursement for emergency or urgently needed services;

b. any other services furnished by a provider or supplier other than (through) the organization that the beneficiary believes are covered under Medicare and should have been furnished, arranged for, or reimbursed by the organization; or

c. a refusal by the health plan to provide services that the enrollee believes should be furnished or arranged for by the organization and the enrollee has not received the service outside the plan.

3. What are a few examples of when the health plan's internal grievance process should be used?

The following is a list of instances in which the grievance process would be used:

- complaints about services in an optional benefit package
- complaints regarding such issues as waiting times, physician behavior and demeanor, adequacy of facilities and other similar enrollee concerns;
- involuntary disenrollment situations (though disenrollment for cause from an HMO or CMP requires prior HCFA approval).

4. Is there a choice as to which procedure to use--the HMO/CMP/HCPP appeals process or the health plan's internal grievance procedure?

No. The two procedures are mutually exclusive. The HMO/CMP/HCPP appeals process must be used when the issue concerns the health plan's refusal to pay for or provide a service that the beneficiary feels is a Medicare-covered service, as explained above in question 2.

5. Does the HMO/CMP/HCPP appeals process apply to any non-Medicare covered benefits?

Yes, the appeals process applies to the basic benefit package under a risk-based contract. This is the lowest option package that beneficiaries can purchase. The basic package may include mandatory additional (above Medicare) benefits and benefits covered by the plan due to "savings" (the difference between the Adjusted Community Rate and the Average Payment Rate). For HCPPs, the appeals requirements do not apply to services outside the agreement with HCFA.

6. Are these provisions applicable to a cost contractor?

Unless otherwise specified, all the provisions explained in this issuance are applicable to a cost contractor with an HMO/CMP contract under section 1876, as well as an organization with an HCPP agreement under 1833. Under a cost-based contract, the appeals process only applies to the low option package which must be exactly equal to Medicare benefits.

7. Who can file an appeal on behalf of the Medicare enrollee?

A Medicare member's authorized representative acting on behalf of a beneficiary, or the representative of the estate of a deceased beneficiary, may file an appeal.

Non-plan physicians, suppliers and institutional providers may also represent a beneficiary in an appeal, if a service has already been

provided. The beneficiary and the non-plan physician, supplier, or provider must either sign a statement that clearly says that the non-plan provider, physician or supplier will act as a representative, or complete a Form SSA-1696, U4, Appointment of Representative. The non-plan provider must waive in writing any right to payment from the beneficiary for issues involving medically unnecessary services or custodial care.

8. Can affiliated physicians, suppliers or providers file an appeal?

The regulations specifically prohibit a direct appeal by physicians and other individuals who furnish items or services under an arrangement with an HMO/CMP/HCPP (42 CFR 417.604(a)(4)). That is, in-plan physicians may not file an appeal. Also, affiliated providers such as hospitals, skilled nursing facilities, home health agencies, etc. may not file an appeal.

9. Can unaffiliated physicians, suppliers or providers appeal a non-payment decision by the HMO/CMP/HCPP?

Non-plan physicians and suppliers may appeal directly to a HMO/CMP/HCPP if they are seeking reimbursement from the HMO/CMP/HCPP for an item or service and they formally waive any right to payment from the beneficiary.

10. Will the HMO/CMP/HCPP get claims from an intermediary or carrier?

For Medicare risk-based contracts: If a non-plan provider has rendered services, usually emergency or urgent care services to your member, then the provider might submit these claims to the local Medicare intermediary or carrier. When an intermediary or carrier identifies the beneficiary as an HMO/CMP member, these claims are transferred to the health plan. These transferred claims are to be treated as requests for payment. The health plan should render a written decision to the member as to whether or not it will pay such claims. This decision is the organization determination, as described below.

For Medicare cost contracts and HCPPs: If a non-plan physician, provider or supplier has rendered services to your member and these claims are submitted directly to the local Medicare intermediary or carrier, the intermediary or carrier will pay the claims. The member may seek reimbursement from the health plan for any deductibles or copayments; this becomes the basis for the organization determination. The health plan should render a written decision to the member as to whether or not it will pay such claims. This decision is the organization determination, as described below.

11. What is an organization determination?

An organization determination is a health plan's decision to deny, provide, authorize or pay for a service. The plan must make this decision within 60 days of the beneficiary's request for a determination and must notify the beneficiary in writing of its reasons for the determination as well as inform the enrollee of his or her right to a reconsideration.

This determination may be in response to a beneficiary request regarding (1) any of the determinations listed under question two, (2) an out-of-plan claim for services, including claims transferred from Medicare carriers and intermediaries, or (3) denial of coverage by an in-plan physician or other plan representative.

Plan physicians and other plan representatives should be made aware that if they advise a beneficiary that a service is not covered or is not necessary, they are making a decision that the member has the right to appeal. Determinations of this nature should be in writing from the health plan.

The determination notice must be mailed within 60 days of the beneficiary's request for coverage or payment. Failure to send a notice within the 60 day timeframe is deemed to be a denial of the enrollees request and enables the enrollee to use the reconsideration process explained below.

12. What type of information must be in the notice to the enrollee?

See the sample notice that is attached.

13. What are the enrollee's responsibilities if dissatisfied with the HMO/CMP/HCPP's organization determination?

He or she must request a reconsideration in writing within 60 days of the date of the HMO/CMP/HCPP notice of organization determination, though the enrollee may request an extension if there are extenuating circumstances. The enrollee may also request reconsideration if the health plan failed to give an organization determination. In either case, the enrollee should file this request with the HMO/CMP/HCPP or with the Social Security Office or Railroad Retirement Office. If the enrollee fails to request a reconsideration in a timely manner, then the organization determination is considered final and binding, unless it is revised in accordance with reopening rules at 42 CFR 417.638 (explained below).

14. What are the HMO's responsibilities in processing a reconsideration?

As a result of the enrollee's request for a reconsideration, the HMO/CMP/HCPP staff must:

1. Assure that the reconsideration decision is not made by the same person or persons who were involved in making the organization determination.

- Review the organization determination and any other evidence. All parties may provide additional evidence, and it may be provided in person or in writing.

- Send a notice of your decision to the parties at interest-- ONLY IF you have completely reversed the organization determination. That is, you have decided to make full payment or provide the requested service. (42 CFR 417.620)

15. What happens if the HMO/CMP/decides that its original determination was completely or partly correct? Can the HMO/CMP/HCPP notify the member that the organization determination is being upheld?

If you uphold your original decision in whole or in part, you may not issue a new notice to the member stating that your original decision to deny or partly deny was correct. You must forward the entire case file, within 60 calendar days from the date of the receipt of the request for reconsideration, to HCFA's contractor for processing reconsiderations:

Network Design Group, Inc. Medicare HMO/CMP Reconsideration
Project 1000 Pittsford-Victor Road Pittsford, New York 14534

As a courtesy, you should inform the enrollee that you have forwarded the case to NDG for the reconsideration determination, and that NDG will provide notice of the final decision with appropriate information regarding further appeal rights directly to the beneficiary. (42 CFR 417.620)

16. If HCFA agrees with the HMO/CMP/HCPP in whole or in part, what recourse does the enrollee have?

If the enrollee is dissatisfied with the HCFA reconsideration determination, (s)he may request a hearing before an Administrative Law Judge (ALJ). A hearing will be held if the amount in controversy is $100.00 or more. The determination of whether the amount is $100 or more is made by the ALJ (42 CFR 417.632 (d)). The request for a hearing must be filed within 60 days of the date of notice of reconsideration.

17. Can HMO/CMPs/HCPPs request ALJ hearings?

An HMO/CMP/HCPP may not appeal a HCFA reconsideration decision. The organization must be made a party to the ALJ hearing; however, the organization does not have a right to request a hearing. (42 CFR 417.632

18. Are there other levels of appeal after the Administrative Law Judge (ALJ) hearing?

Any party to the hearing, including the organization who is dissatisfied with the hearing decision, may request the Appeals Council of the Social Security Administration to review the ALJ decision or dismissal. (42 CFR 417.634) The Appeals Council may also review an ALJ decision without such a request "on its own motion".

A party or organization may request judicial review of the case if the Appeals Council denied the party's or the organization's request for review, or affirmed the ALJ decision, and the amount in controversy is $1000 or more. (42 CFR 417.636)

19. Which decisions may be reopened?

A reopening is not a type of appeal. It is an administrative procedure under which the entity that made an appeal decision reexamines that decision for a specific reason. Such reasons would be to correct an error, in response to suspected fraud, or in response to the receipt of information not available or known to exist at the time the claim was initially processed.

An initial, revised, or reconsidered determination made by the HMO/CMP/HCPP or HCFA or a decision of an Administrative Law Judge or the Appeals Council, may be reopened within 12 months of the notice of the organization or reconsidered determination for any reason stated above, or within 4 years for just cause. A decision may be reopened at any time if it was "procured by fraud or similar fault." A decision that is unfavorable to the party thereto may be reopened at any time to correct a clerical error or an error "on the face of" the evidence. (42 CFR 417.638 and 42 CFR 405.750)

20. At what point is an HMO/CMP/HCPP required to pay a claim or render a service based on a determination made during the HMO/CMP/HCPP appeals process?

Once the HMO/CMP/HCPP receives the reconsideration determination from Network Design Group, HCFA's contractor for processing HMO/CMP/HCPP reconsiderations, payment is due or the service must be rendered within 60 days of the date of receipt. (42 CFR 417.440(a)(2))

SAMPLE ADVERSE ORGANIZATION DETERMINATION WITH NOTICE OF APPEAL RIGHTS

Dear (name of beneficiary):

GIVE DETAILS OF DENIAL OF CLAIM OR MEDICAL SERVICE, INCLUDING A DESCRIPTION OF THE SERVICE AND REASONS FOR DENIAL

If you believe this determination is not correct, you have the right to request that we reconsider our decision. This request may also include additional evidence to support the reasons you feel this claim should be reconsidered. You must file this request in writing within 60 days of the date of this notice. Send your request to:

NAME AND ADDRESS OF HEALTH PLAN

You may also file with an office of the Railroad Retirement Board, if you are a railroad annuitant, or a Social Security Office. But, if you file with either office, it will transfer your request back to (NAME OF HEALTH PLAN) because we are responsible for processing requests for reconsideration. If we do not rule fully in your favor, we will send your reconsideration request to a Health Care Financing Administration contractor for processing.

You can have a family member, friend, lawyer or someone else help you. Some lawyers do not charge unless you win your appeal. There are also groups, such as legal aide services, who will give you free legal service if you qualify.

If you have any questions about this notice, you may contact a Member Services Representative at (TELEPHONE NUMBER).

Sincerely,